DWH Medical Center, P.C.

524 West Broad Street
Quakertown, Pa 18951
Tel: (215) 538-6113
Fax:(215) 538-6117

35 East Elizabeth Avenue, Suite 3
Bethlehem, PA 18017
Tel: (610) 419-3388
Fax: (610) 419-3266

Date: _____/_____/_____ **Referring Physician**: _____

Name: _____ **Family Doctor**: _____

DOB: _____/_____/_____

PLEASE COMPLETE THESE FORMS PRIOR TO YOUR APPOINTMENT AND BRING THEM WITH YOU THE DAY OF YOUR SCHEDULDED APPOINTMENT. If you are unable to fill them out yourself, please have your family doctor give you a list of your medical history and recent medications. You will need all of the documentations prior to your appointment so we better assist you with this form.

- **What is your chief complaint?** (Example: 30% Low Back Pain and 70% Right Leg Pain)

_____

- **When did it start?** (Example: 2 months ago or 07/26/**)

_____

- **Did you sustain any trauma immediately prior to the onset?** **YES** **NO**
- **Is this work related or motor vehicle accident related?** **YES** **NO**
- **Do you have an attorney?** (Please provide their contact information) **YES** **NO**

- **Please describe the trauma.**

_____

_____

_____

- **Is the pain Constantly, Intermediately, or both?** (Example: constant back pain with intermediate left leg pain)

_____

_____

- **Please describe the characteristics of your pain?** (Example: sharp, dull, burning, throbbing, tingling, etc.)

_____

_____

- **What makes the pain worse?** (Please circle)

Sitting Standing Walking Lying flat Bending Over Lifting Others: _____

_____

- **What makes the pain better?** (Please circle)

Sitting Standing Walking Lying flat Lifting Changing Positions Others: _____

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Taking medications (please list_____)

- **Past Medical History** (Please circle all that applies)

AIDS/HIV Alcoholism Asthma Cancer Diabetes Emphysema Epilepsy Heart Disease

Hepatitis Herpes High Blood Pressure Multiple Sclerosis Pacemaker Seizures Stroke

Thyroid Disorder Tuberculosis Fibromyalgia Depression Bipolar Disorder Schizophrenia

Anxiety Disorder Other Psychiatric Issues Irritable Bowel Syndrome Chronic Pelvic Pain

Migraine Other: _____

- **Past Surgical History:**

Surgery	Year

- **Family History** (Please list all significant family medical history such as bleeding problems (hemophilia), psychiatric disorder, chronic pain, or any substance abuse)

_____

_____

_____

- **Social History**

Who do you live with now? _____

Do you have any children? _____ How many? _____ How is their health? _____

Are you currently working? _____ If not, why not? _____

Why did you stop? _____

What do/did you do for a living? _____

Do you smoke? _____ If yes, how much? _____ (per day on average)

Do you drink? _____ If yes, how much? _____ (per day on average)

Do/did you use any illicit drugs? _____ What kind and how much? _____

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Have you ever gone through rehab for drug and alcohol abuse? _____

Are you currently pregnant or plan to become pregnant? **YES** **NO**

Have you ever been discharged from a doctor's office because of noncompliance not following their directions?
Yes No

- **Review of Systems**

In the past month, have you been experience any significant (Please circle all that applies)

Weight loss/gain Fever/chills Changes in hearing/vision Dizziness Pass out

Shortness of breath Productive cough Chest pain Abdominal pain

Diarrhea/constipation Weakness in the extremities Lost control of bowel/urinary functions

Bleeding problems Rashes Depression Suicidal thoughts Homicidal thoughts

Others: _____

- **Images** (X-Ray, CT Scan, Bone Scan, etc.)

Study	Date	Where

- **Spine Injections**

	Doctor	Date	Helpful?	How long did it last?
Epidural steroid injection				
Facet Injection				
Radiofrequency ablations				
SI joint injections				

- **Spine surgery**

	Doctor	Date	Helpful?	How long did it last?

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- **Current Medication** (Please list all meds including vitamins and OTC meds)

Medication	Why prescribe	Dosage

- **Are you allergic to any medications?** (Please list and describe reaction)

Medications	Reactions

IV contrast allergy? **YES** **NO**

Shell-fish allergy? **YES** **NO**

- **What other facilities did you go to?**

	How long?	Helpful?	Reason stopped

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- What have you tried?

Medication	Dosage & Directions	How Long?	Helpful?	Reason Stopped
Ibuprofen (Advil, Motrin)				
Acetominophen (Tylenol)				
Aspirin				
Naproxen (Aleve, Naprosyn)				
Diclofenac (Voltaren)				
Etodolac (Lodine)				
Ketorolac (Toradol)				
Nabumetone (Relafen)				
Meloxicam (Mobic)				
Carisoprodol (Soma)				
Cyclobenzaprine (Flexeril, Amrix)				
Diazepam (Valium)				
Metaxalone (Skelaxin)				
Methocarbamol (Robaxin)				
Tizanidine (Zanaflex)				
Gabapentin (Neurontin)				
Pregabalin (Lyrica)				
Topiramate (Topamax)				
Amitriptyline (Elavil)				
Duloxetine (Cymbalta)				
Venlafaxine (Effexor)				
Nortriptyline (Pamelor)				
Hydrocodone/APAP (Vicodin, Lortab, Norco)				
Oxycodone/APAP (Percocet, Endocet, Tylox, Roxicet)				
Methadone				
Morphine				
Fentanyl patch				
Oxycontin				
Lidoderm Patches				
Flector Patches				
Voltaren Gel				
Other medications				

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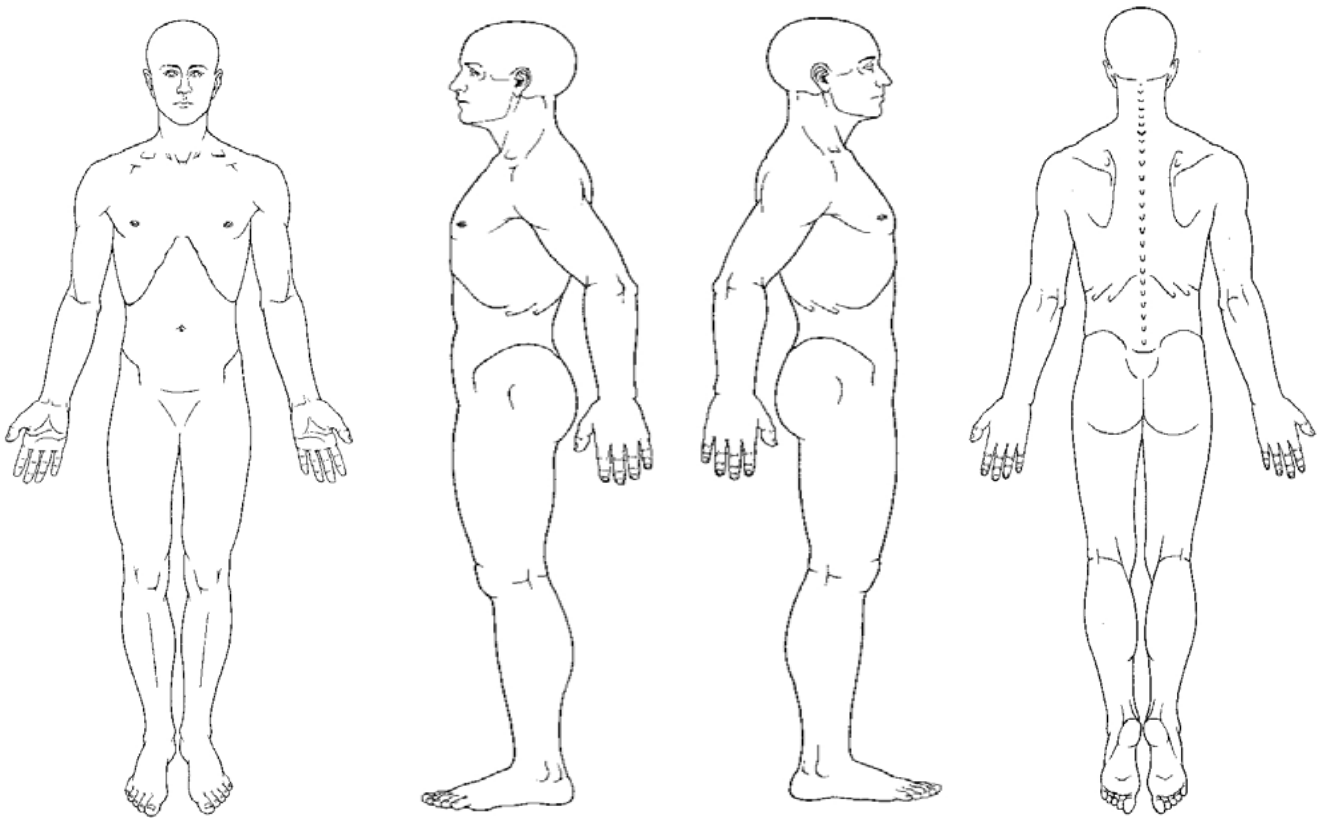
	How Long?	Helpful?	Reason Stopped	Comments
Chiropractors				
Massage therapy				
Physical therapy / Aquatic therapy				
Tens Unit				
Heat Compress				
Cold compress				
Acupuncture therapy				
Psychotherapy / Biofeedback				
Behavior modification therapy				

Please circle on image the areas where you feel pain.



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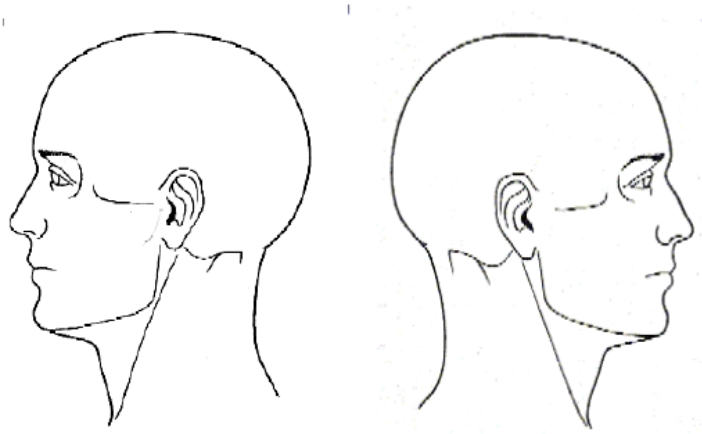
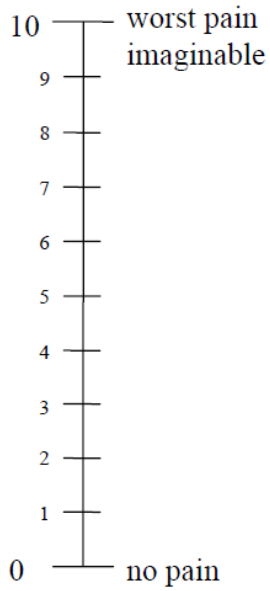
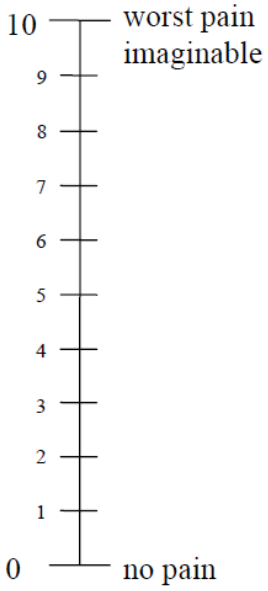


Please rate the severity of your pain (BOTH baseline and with activity).

BASELINE



WITH ACTIVITY



Patient Signature: _____

Date: _____